Rating Health Care Plans in the Care of Patients with Traumatic Head Injury

by the

Missouri Head Injury Advisory Council

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Missouri Head Injury Advisory Council
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Preface

In January 1996, Don Claycomb, Ph.D., Chairman, at the direction of the Missouri Head Injury Advisory Council assigned the council's Managed Care and Rehabilitation Committee the task of developing recommendations with regard to managed care plans for persons with traumatic head injury, as well as for all Missourians who may be at risk of receiving a traumatic head injury. The committee, chaired by John J. Oro', M.D., proceeded to study the issues and made its recommendations. The council adopted these recommendations March 1997.

About the Missouri Head Injury Advisory Council . . .

The Missouri Head Injury Advisory Council was created by Executive Order in 1985, and by law in 1986, to plan and make recommendations for a service delivery system, including prevention, for survivors of head injuries and their families.

The 25 member council is to be advisory and shall, in accordance with Section 192.735 RSMo.:

(1) Promote meetings and programs for the discussion of reducing the debilitating effects of head injuries and disseminate information in cooperation with any other department, agency or entity on the prevention, evaluation, care, treatment and rehabilitation of persons affected by head injuries;

(2) Study and review current prevention, evaluation, care, treatment and rehabilitation technologies and recommend appropriate preparation, training, retraining and distribution of manpower and resources in the provision of services to head injured persons through private and public residential facilities, day programs and other specialized services;

(3) Recommend what specific methods, means and procedures should be adopted to improve and upgrade the state's service delivery system for head injured citizens of this state;

(4) Participate in developing and disseminating criteria and standards which may be required for future funding or licensing of facilities, day programs and other specialized services for head injured persons in this state; and

(5) Report annually to the commissioner of administration, the governor, and the general assembly on its activities, and on the results of its studies and the recommendations of the council.

Introduction and Purpose

Over two million Missouri residents are enrolled in managed care plans, usually referred to as HMOs (Health Maintenance Organizations). State agencies and private business are considering managed health care plans as a way to provide care, while at the same time controlling costs. Missouri's Medicaid program has implemented MC+, managed care for low income families, in several areas of the state. The state does not, however, require enrollment in MC+ for Medicaid recipients with a traumatic head injury who are "Permanently and Totally Disabled (PTD)", who are institutionalized, or who are in home and community based waivered programs. A Medicaid pilot project, HC0+, is being developed in central Missouri for purposes of managing care for persons with disabilities, including persons with traumatic head injuries. The program will be voluntary for Medicaid recipients. One of the features of the plan is that a physiatrist may be the primary care physician. A physiatrist is a medical doctor who specializes in physical medicine and rehabilitation. In most plans, a physician in the specialty of family practice, internal medicine, or pediatrics is the primary care physician. The Missouri Department of Mental Health contracted with a consultant firm to assess its readiness for managed care with regard to mental health and substance abuse services delivered or contracted by the department.

As the number of Missourians participating in managed care health plans in the state is increasing, the Missouri Head Injury Advisory Council has developed an HMO rating system to assist:

(1) individuals in selecting plans,

(2) companies and businesses in selecting health care plans for their

employees,

(3) state agencies, particularly Medicaid, in developing managed care plans that are sensitive to the needs of persons who are injured, and

(4) policy makers in developing health plans which will prevent injuries and meet the treatment and rehabilitative needs of survivors of head injury and their families.

The council recognizes that not all long-term care and social needs will be addressed by health maintenance organization plans and will continue to advocate for those type of services to be addressed by federal, state and local programs in a coordinated fashion.

Background: Overview of Service Delivery

State and Federal Initiatives

With rapid advances in medical technology and improved emergency medical and trauma systems persons with traumatic head or brain injuries are surviving who may not have lived ten to twenty years ago. As a result, individuals and advocacy organizations, such as the Brain Injury Association, formerly the National Head Injury Foundation, have advocated for improved systems of care in order to improve quality of life, prepare individuals with a traumatic head injury for future employability and independent living, and to deter secondary disability. The model service system includes such services as medical rehabilitation, long-term care, vocational rehabilitation, and community re-entry programs. Several initiatives have been undertaken by federal, state, and private programs. Some of these initiatives are described in order to understand the efforts to improve and expand the system of care.

In 1983, Congress enacted a law authorizing the secretary of the Department of Transportation to request the National Academy of Sciences to perform a study on trauma. The resulting book, Injury in America*,* published in 1985, revealed that injuries are the leading cause of death and disability in children and young adults. The report stated that "Injury greatly surpasses all major disease groups as a cause of prematurely lost years of life, because it is the preeminent cause of death among children and young adults. More years of future work life are lost to injury than to heart disease and cancer combined.'' The report outlined several recommendations for preventing and reducing the debilitating effects of injury through appropriate treatment and rehabilitation services which have been embraced by federal and Missouri policymakers.

Missouri began addressing service delivery systems for persons with traumatic head injuries and their families in 1984 by way of a legislative Joint Interim Committee on Head Injury. The Missouri General Assembly passed a senate concurrent resolution calling for five member of the House of Representatives; five members of the Senate; state agencies representing mental health (which administers alcohol and drug abuse, psychiatric, and developmental disabilities programs), vocational rehabilitation, and health statistics; and Missouri Protection and Advocacy Services to study the concerns of families, survivors, professionals, and others with regard to state services for individuals with traumatic head injuries and their families. The Brain Injury Association of Missouri (formerly the Missouri Head Injury Foundation) advocated for the study and assisted with testimony.

The Joint Interim Committee's first recommendation was that the Missouri General Assembly pass a state safety belt law to prevent injuries and fatalities. Other recommendations included:

> (1) that the Governor create an advisory council to continue studying the issues and to make recommendations for developing, expanding, and coordinating services;
>
> (2) that the State Chest Hospital administered by the Missouri Department of Health be converted to a rehabilitation facility offering head injury rehabilitation; and
>
> (3) that state funding be appropriated for rehabilitation and community support services.

On March 5, 1985, the Governor signed the safety belt law and created the council under an Executive Order. Legislation also passed that year changing the mission and the name of the State Chest Hospital to the Missouri Rehabilitation Center. Also, funding was appropriated for the first time to the Missouri Department of Health for purchasing rehabilitation and community-based support services. Since 1985, the Missouri General Assembly has appropriated state funding for post acute rehabilitation, transitional living rehabilitation, vocational and substance abuse rehabilitation through the Missouri Rehabilitation Center and has contracted with community programs for post acute (functional living) rehabilitation, supported employment and community support

services. (The Missouri Rehabilitation Center was transferred to the University of Missouri-Columbia July 1, 1996).

In April 1986, at the federal level, the U.S. Assistant Secretary of Education announced a major programmatic initiative in response to the rapid and uncoordinated growth in rehabilitation programs and resources. Five national demonstration projects were funded by the National Institute on Disability and Rehabilitation Research (NIDRR) to focus on the comprehensive delivery of services from injury through intensive neurological care, comprehensive medical and psychosocial rehabilitation, community reintegration and long-term follow-up. And, in 1989, again at the direction of Congress, the Department of Health and Human Services Interagency Head Injury Task Force issued a report and recommendations for the federal, state and private entities to address a comprehensive systems approach to prevent head injury and to rehabilitate survivors of a traumatic head injury. Many of these recommendations were already being addressed in Missouri.

The Missouri General Assembly passed legislation in 1986, creating the Missouri Head and Spinal Cord Injury Registry mandating hospitals to report to the Missouri Department of Health head injuries and services provided from the scene of the injury until hospital discharge. This provides a mechanism for the state to ascertain the number of new injuries each year, cause of injuries, contributing factors relating to the injuries (such as alcohol), care provided from scene of injury to hospital discharge, and to where patients are discharged.

The General Assembly also passed legislation in 1987 establishing a statewide trauma system. Ambulances are required to bypass the nearest hospital and transport an injured patient to a trauma center under certain conditions. During 1989, state legislation passed expanding the Missouri Medicaid program to include comprehensive day rehabilitation for post-acute head injury patients as the result of legislation.

Missouri also has several state laws designed to reduce injuries associated with motor vehicle crashes including a safety belt law, motorcycle helmet law, zero tolerance for minors, child safety seat, and DWI law which cites .10 as the BAC (Blood Alcohol Content) level for driving while intoxicated.

In 1992, a RFP (Request for Proposal) was issued by the U.S. Rehabilitation Services for purposes of establishing initially four regional comprehensive head injury rehabilitation and prevention centers as the result of funding from Congress. Four were established with each regional center covering, for the most part, the states in that federal region. Two years later two more centers were funded. The funding has since expired for the first four centers and the centers which were funded later were able to obtain separate funding for one more year, which is the current fiscal year. Missouri did not receive a grant nor was included in the other projects.

On July 29, 1996, the President signed legislation, the TBI Act, authorizing $24.5 million over the next three years to provide services for people with brain injury, prevent brain injuries and perform research. For Fiscal Year 1997, Congress has appropriated:

(1) $2.6 million to the Centers for Disease Control and Prevention to develop prevention and education strategies;

(2) $2.875 million to the Health and Services Administration to carry out model service projects at the state level; and

(3) a directive to the National Institutes of Health to carry out a national consensus conference and produce a white paper on brain injury in the United States

What is the incidence of traumatic head or traumatic brain injury?

In Missouri . . .

Each year, hospitals report that at least 5,000 Missourians have sustained a traumatic head or brain injury. Almost half of those injured are as the result of motor vehicle crashes. Falls are the second leading cause and are prevalent among young children and the elderly. Other injuries are caused by sports, recreational injuries,

industrial incidents, assaults or weapons. Males between the ages of 15-24 are over represented. Alcohol tends to be a contributing factor.

In 1993 . . .

• The Department of Health reported that 5,221 Missourians received a traumatic head injury; 1,206 persons died as the result,

• Almost half (45.32%) of those reported were injured as the result of motor vehicle crashes; falls were the second leading cause (23.77%); followed by assaults (12.74%); self-inflicted (6.07%); and other (12.10%),

• More than half (65.89%) of those who sustained a traumatic head injury were males.

What is a traumatic head or brain injury?

Missouri has defined "Head injury'' or "traumatic head injury'' as: "a sudden insult or damage to the brain or its coverings, not of a degenerative nature. Such insult or damage may produce an altered state of consciousness and may result in a decrease of one or more of the following: mental, cognitive, behavioral or physical functioning resulting in partial or total disability. Cerebral vascular accidents, aneurysms and congenital deficits are specifically excluded from this definition'' (Section 192.735 RSMo). This definition is very similar to the definition for traumatic brain or acquired brain injury in the federal TBI Act.

Survivors of head injury or brain injury require extensive services over an extended period of time. Although the injury is not always visible, it may cause physical, emotional, intellectual, social and vocational changes. There are two types of head injury: closed head injury and open head injury. A "closed head injury" refers to damage that occurs within the skull after a blow to the head. Although the skull may stop on impact, the brain will often continue to whip back and forth against the skull from within causing damage. An "open head injury" is a visible assault such as a gun shot wound.

Symptoms

The symptoms of head injury may vary greatly, depending on the extent and location of the injury. The following are three types of impairments associated with head injury. Any or all of the impairments may occur in varying degrees and there may be other symptoms than those listed below.

• Physical impairments; including speech, vision, hearing and other sensory impairments, headaches, lack of coordination; spasticity of muscles, paralysis of one or both sides and seizure disorders. Although many survivors of head injury may appear to be recovered physically, they may still have problems with visual perception or fine motor control.

• Cognitive impairments; which may result in memory deficits, either long or short term; and problems with concentration, attention, perception, communication, reading, writing, planning, sequencing or judgment. Learning problems which have been identified include decreased ability for abstraction, less initiative, and distractibility.

•Psycho-Social-Behavior-Emotional impairments; including fatigue, mood swings, denial, self-centeredness, anxiety, depression, lowered self esteem, sexual dysfunction, restlessness, lack of motivation, inability to self-monitor, difficulty with emotional control, inability to cope, agitation, excessive laughing or crying or difficulty relating to others. Personality can be altered and the person may become argumentative or become socially withdrawn and unable to interact with peers. Often a person with a head injury will insist he or she can understand completely, when in actuality is totally confused.

While the length of coma or loss of consciousness is often used as a guide for assessing severity of injury, experts cite that even a short duration of coma or loss of consciousness may have long term neurological effects.

Model Systems of Care . . .

The Missouri Head Injury Advisory Council has over the years outlined the components of a comprehensive service delivery system for persons with traumatic head injury and their families. The Council's recommendations have been similar to the recommendations made by the federal Interagency Task Force and the Model Systems Projects. The service delivery system addresses prevention, emergency medical services, trauma systems, acute care and rehabilitation, post-acute rehabilitation, community services, and service coordination.

Prevention

Prevention is the only cure for traumatic head or brain injury. Injury in America outlines three general strategies for preventing injuries: (1) Persuading persons at risk of injury to alter their behavior for increased self-protection such as using safety belts or helmets, (2) requiring individual behavior change by law or administrative rule such as seat belt and child safety laws, (3) and providing automatic protection such as requiring the installation of automatic seat belts or air bags.

Primary Prevention

Model systems of care are designed to provide primary, secondary and tertiary prevention. Primary prevention (i.e., preventing injuries from occurring) includes educating patients to use seat belts, to wear helmets, to not drink and drive, and other recommendations designed to reduce falls, especially among the elderly. These recommendations also address environmental hazards such as eliminating throw rugs or installing grab bars in tubs or nonskid showers.

Secondary Prevention

Secondary prevention minimizes the eventual disability by preventing further damage through several procedures. State-of-the-art equipment and facilities as well as highly trained health care providers are needed for successful secondary prevention in persons with a traumatic head injury. Tertiary prevention refers to the long-term care of persons with traumatic head injury designed to minimize the disabilities associated with the injury.

"The acute care and rehabilitation management of persons with TBI is best achieved in a TBI model system of care that provides a continuum of coordinated services, including properly trained and equipped EMS personnel; a designated neurotrauma center, a comprehensive TBI inpatient and outpatient rehabilitation program; appropriate psychological, social, and vocational services to facilitate return to the community and productive living; and an aggressive and effective follow-up program." (Journal of Head Trauma Rehabilitation, Vol. 8, No. 2, June 1993. Model systems of care for individuals with traumatic brain injury, Ragnarsson, Kristjan T, M.D., Thomas, J. Paul, Ph.D. and Zasler, Nathan D., M.D.) Rehabilitation should begin as soon after the injury as possible. Behavior modification programs, rehabilitation services at home, case management, and community living options are also components of a model system of care.

The earlier rehabilitation begins, the better the results. Acute care saves lives, but medical rehabilitation determines quality of life, future employability, and deters secondary disabilities. (Medical Rehabilitation and Public Policy Prepared by Rand Snell, legislative staff of Senator Lawton Chiles, February 1993.)

Emergency Medical Services

Treatment and care begins at the scene of the injury. The outcome of injury not only depends on the severity of injury, but also on the speed and appropriateness of treatment. The hour from the scene of the injury through the emergency department is referred to as the "golden hour." The mortality will increase by 50% if there is delay in care beyond the golden hour (Journal of Head Trauma Rehabilitation. "The Trauma Center as a Continuum of Care for Persons with Severe Brain Injury", Morgan, S. Anthony, M.D. FACS., March 1994.) Emergency medical services personnel are trained to provide immediate treatment and to determine which patients need to

be transported to a trauma center. The American College of Surgeons Committee on Trauma has established guidelines for emergency and trauma care.

Trauma Systems

Trauma centers have special teams and services to care for the severely injured. There are three recognized levels of trauma centers: Level I and II trauma centers manage the most severely injured and Level III which care for those who are less severely injured. Level III trauma centers may stabilize and transfer those with major injuries to a Level I or Level II hospital. Trauma centers have special teams and services to care for persons with severe injuries.

Rehabilitation

Rehabilitation should not be separate and apart from the initial medical response to the injury. Even in an intensive care unit (ICU), rehabilitation services can and should be provided to persons with severe injuries, before muscles are weakened, mobility is lost, psychological or physiological damages solidifies and secondary disabilities are compounded.

The Missouri Head Injury Advisory Council has defined three types of rehabilitation programs: (1) Acute Brain Injury Rehabilitation, (2) Functional Living Rehabilitation and (3) Transitional Living Rehabilitation. Acute rehabilitation focuses on physical and gross cognitive deficits. The program is designed to prevent and/or minimize chronic disabilities while restoring the individual to the optimal level of physical, cognitive and behavioral functioning. The rehabilitation program should be carefully coordinated and implemented as soon after onset of injury as is medically feasible.

Interdisciplinary Rehabilitation

To decide what types of services or therapies the patient needs, the patient should be evaluated by an interdisciplinary team of professionals. The team develops a rehabilitation program to address the patient's problems. These problems may be related to memory, attention, movement, balance, personality changes, difficulty with complex thinking and judgment, inappropriate behavior, and difficulty with speech and language.

The interdisciplinary team of rehabilitation specialists may include: neuropsychologist/psychologist, speech pathologist, physical therapist, occupational therapist, nurse, special educator, recreational therapist, vocational rehabilitation counselor, physician, physiatrist, case manager, social worker, and/or counselor. The survivor, family or guardian should be involved in the development of the rehabilitation plan. The plan should provide goals and objectives that focus on restoring the patient's identified areas of deficit. Team conferences should be held regularly to increase the team's ability to address a variety of clinical problems that might interfere with the patient's recovery and rehabilitation. Pediatric programs should include special education and school reentry programs.

Families generally need and want information on head injury, expected outcomes, services available and so forth, while their family member is in the hospital. Social workers and discharge planners should assist families in receiving the information and in obtaining the appropriate services following hospital discharge. Families should be encouraged to become active in the rehabilitation process immediately after injury and continue their involvement both during and after hospitalization.

Follow-up Services

Most patients will require regular follow-up by the various rehabilitation disciplines to continue to address their medical, nursing, psychological, social, and vocational needs.

Post-injury needs can range from full time care to community reintegration. The order in which services are used can also vary; some people will move from acute medical care into community integration while others may require extended periods of acute rehabilitation care, post-acute and/or nursing care. Neuropsychological

remediation programs that provide compensatory strategies for impaired attention, memory, mental flexibility, and processing speed should be an integral part of the therapeutic program. Counseling services should be available to patients and families to ease their emotional adjustment to deficits as the result of the injury. Neuropsychologists require specialized training and expertise in evaluation and treatment of persons with head injuries.

The Missouri Head Injury Advisory Council has defined a Functional Living Rehabilitation Program as one which provides intensive rehabilitation with goal directed services to persons who have either completed acute rehabilitation or who have no major acute rehabilitation needs. Emphasis in this program is on functional cognitive, memory, or perceptual deficits, and appropriate interpersonal skills. Services may be delivered on an inpatient (residential) or outpatient (day program) basis. Under the state Medicaid program this service is defined as comprehensive day rehabilitation.

The Council has defined a Transitional Living Rehabilitation Program as one providing intensive rehabilitation with goal directed services to persons who have completed acute and functional living rehabilitation programs or who have no significant need for such services prior to transitional living programs. In these programs, participants would typically move from close observation and supervision to independent living with minimal supervision. Transitional living programs may exist independently or may be part of a larger program. The program should provide safe, accessible housing which allows transition from group living situations to independent living.

The interdisciplinary team in these programs should consist of the same disciplines as the inpatient rehabilitation team. Each team member should be familiar with the resources within the community including special driver evaluation and training, prevocational and vocational services, work hardening programs, behavioral management, transitional and independent living centers, and long-term care facilities.

The goal of rehabilitation is to enable a survivor of a traumatic head injury to return to his/her home, school or employment. Many survivors will require extensive rehabilitation or programs which specialize in prevocational or vocational rehabilitation in order to be able to engage in competitive employment. For those who will not be able to engage in competitive employment without some type of assistance, other alternatives will need to be available. Persons who are wheelchair dependent will require specialized transportation.

The discharge planner and/or the social worker is an integral team member who interface with patients, their families and community resources/programs to ensure that when the patient is ready for discharge, the resources are in place. Staff should have established relationships with other community and state case managers and programs/services such as those listed under community programs.

Community Support Services

Community support services provide ongoing or intermittent support to survivors of head injury and their families, thus enabling them to live in the community on their own, with family, or other assistance. These services may exist independently or be part of a larger program. Such services provide ongoing or intermittent support in several areas including recreation, counseling, transportation, therapies, and other support services. Services include: day programs; prevocational/pre-employment training; vocational rehabilitation; employment; residential services/housing; supported housing/living; home health care; personal care assistance; respite care; counseling; follow-up; transportation; independent living center services; recreation/socialization activities; peer support groups/family support groups; and substance abuse treatment.

Rehabilitation Benefits

Rehabilitation limits the burden of disability on patients, families, the long-term interest of patients, insurers, and society at large. Most patients can benefit from rehabilitation at all stages of their treatment, even if months after the initial injury. To be effective, it should begin very early. Patients benefit through improved length and quality of life, increased independence and restored earning power over their worklife; government gains

through decreases in state assistance, and insurers and the consumers benefit through decreased medical and nursing home costs.

Rehabilitation cuts long-term disability costs an estimated $1 billion to $2 billion annually. A survey by the Health Insurance Association of America showed an average cost savings of $11 per dollar invested. From the insurer's perspective, success is achieved when the claimant returns to work; the claimant recovers medical to the point of full employability; or benefits terminate because the claimant begins to receive Social Security Disability Income; or is otherwise no longer eligible for benefits.

Blue Cross/Blue Shield of Massachusetts estimates that only 1.5% of annual premiums, amounting to $3.70 for the average policy, goes toward rehabilitation, which is consistent with Medicare data showing that only 1.5% of all payments were directed to rehabilitation facilities in 1987.

Studies of various disability groups indicate substantial reductions in hospital stays and readmissions, particularly if rehabilitation is begun early in the patient's acute care. Many studies report that rehabilitation increases the likelihood of discharge to the patient's home, as opposed to a nursing home or other facility.

Because patients with head injury require intense therapy, and because they are generally young people with lifetime earning power at risk, the lifetime costs for head injury patients have been estimated between $4.1 million and $9 million per patient.

Recent studies of patients receiving early, formalized traumatic brain injury rehabilitation showed they had stays one-third the length of similarly injured patients not receiving formalized TBI rehabilitation. (Recovery or Dependence: Choices in Medical Rehabilitation, Snell, Rand, July 1993.)

Trends of Managed Care

The focus of managed care is short-term cost savings and profit making, because reimbursement on an annual basis dictates that managed care providers stay focused on the short term. By contrast, insurers and reinsurers dealing with the long-term consequences of disability, recognize that medical rehabilitation reduces overall costs. Under current federal regulation, HMOs are required to provide coverage of short-term inpatient and outpatient rehabilitation services, and physical therapy, if there is expectation of significant improvement within a sixty-day period.

The role of gatekeeper or primary physician is crucial. Because of that, and because of the special needs of many patients, including those with disabilities, a number of consumer and provider groups have asked to have an option of a rehabilitation specialist as the gatekeeper and primary care provider. The pilot managed care project for persons with disabilities, Missouri HC+, recognizes that concern and will allow for a physiatrist to be the primary care physician.

Other trends . . .

• Increasing number of members to plans.

• Less choice (too costly to go out of network).

• May not have primary physician of choice.

• Less contact with specialized care.

• Physician may not be willing to refer to specialized care.

• Fewer hospital days.

• Shorter and less rehabilitative services.

These trends in managed care run counter to the spectrum of health care required by patients with traumatic head injury as outlined in this report. The Missouri Head Injury Advisory Council is concerned that managed care plans in Missouri do not adequately address the health care needs of patients with a traumatic head injury. Over time, this will result in poorer outcome for those afflicted and overall higher health care costs.

Rating Scale

Prevention

1. Does the health plan have any head injury prevention educational component or programs, such as HEADS UP? (Think First) ?
yes _____ **no** _____

1.2. If not, does the plan provide any support to such programs?
yes _____ **no** _____

2. Does the plan provide educational (written) materials to members?
yes _____ **no** _____

3. Does the plan encourage providers to include prevention education during health screening or checkup, such as the provider asking if the person uses a seat belt?
yes _____ **no** _____

Emergency Care

4. Does the plan provide coverage for emergency medical care in a manner which encourages their members to receive necessary treatment?
yes _____ **no** _____

Trauma Systems

5. Does the plan allow transfer to the nearest appropriate level trauma center in accordance with state law and regulations, which follow nationally recognized standards?
yes _____ **no** _____

Rehabilitation Services

6. Does the plan cover the following therapies and are the therapies limited by days or amounts?
• occupational
• physical
• speech/language
• cognitive
• behavioral
yes _____ **no** _____

7. Does the plan allow transfer to CARF approved rehabilitation centers?
yes _____ **no** _____

Follow–up Services

8. Does the plan benefits include long term care, such as in-home support?
yes _____ **no** _____

Patient Autonomy and Due Process

9. Does the plan provide information on due process for members and physicians/providers, including a grievance procedure?
yes _____ **no** _____

10. Does the plan provide an ombudsman?
yes _____ **no** _____

11. Does the plan provide the Missouri Department of Insurance consumer affairs number (1-800-726-7390)?
yes _____ **no** _____

12. Does the plan provide for prior notification when there is a hange of the health care provider within a health plan?
yes _____ **no** _____

Case Management

13. Does the plan have a written procedure for deciding which cases need case management?
yes _____ **no** _____

14. Does the plan describe arrangements/agreements with public health, education, mental health, available community and social service agencies in order to coordinate services with these agencies?
yes _____ **no** _____

15. Does the plan have outreach and follow-up activities?

Out of Plan Arrangements

16. Does the plan have out-of-plan arrangements for specialized services such as assistive technology, head injury rehabilitation, in-home care, and community socialization?
yes _____ **no** _____

17. Does the plan restrict access to this care?
yes _____ **no** _____

18. Does it maintain records on the rates of referral?
yes _____ **no** _____

Accreditation

19. Is the HMO accredited by NCQA (National Committee on Quality Assurance)?
yes _____ **no** _____

Conclusions

Traumatic head or brain injury remains a major health problem in Missouri. It has a long term impact on the individual, families and the state. Managed care plans with their focus on short term goals may not be providing adequate care for this group. Without appropriate coverage, it is likely that the cost for the state will rise, since providing an adequate spectrum of care to these patients has been shown to lower overall cost.

The Missouri Head Injury Advisory Council proposes rating the health care provided by managed care plans to patients with head injury. The ranking should be made available to individuals, businesses, state agencies and

policy makers to assist them in selecting the best plans. The ranking should also encourage plans to compete with each other to provide for the care of these patients.

Appendices

Acronyms

Glossary

Missouri Head Injury Advisory Council

Acronyms

CARF--Commission on Accreditation of Rehabilitation Facilities

CDC--Centers for Disease Control and Prevention

EMS--Emergency Medical Services

HMO--Health Maintenance Organization

ICU--Intensive Care Unit

OT--Occupational Therapist

PT--Physical Therapist

PHPs--Prepaid Health Plans

PPO--Preferred Provider Organization

NCQA--National Committee for Quality Assurance

TBI--Traumatic Brain Injury

Glossary

This glossary, in part, is taken from the *Partnerships for Healthier Families: Principles for Assuring the Health of Women, Infants, Children, and Youth Under Managed Care Arrangements* produced by the Association of Maternal and Child Health Programs November 1996. Development of the document was supported by a Cooperative Agreement (MCU# 116046-06-1) from the Maternal and Child Health Bureau (Title V, Social Security Act), Health Resources and Services Administration, Department of Health and Human Services. Some of the definitions have been modified and others have been added so as to relate to head injury.

Assistive Technology Device

Any item, piece of equipment, or product system, whether acquired commercially off a shelf, modified, or customized, that is used to increase, maintain, or improve the functional capabilities of people with disabilities.

Assistive Technology Service

Any service that directly assists a person with a disability in the selection, acquisition, or use of an assistive technology device. The term includes:

a. evaluating the needs of a person with a disability, including a functional evaluation of the person in the person's customary environment;

b. purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices by persons with disabilities;

c. selecting, designing, fitting, customizing, adapting, applying, retaining, repairing, or replacing assistive technology devides;

d. coordinating and using other therapies, interventions, or services with assistive technology devices;

e. training or technical assistance for a person with a disability or, if appropriate, that persons's family; and

f. training or technical assistance for professionals, employers, or other individuals who provice services to, employ, or are otherwise substantially involved in the major life functions of a person with disabilities.

Acute (Medical) Rehabilitation

Begins in the acute phase and continues with an integrated, comprehensive inpatient rehabilitation care facility specifically designed to care for individuals with traumatic brain injury and their families. These services focus on physical and cognitive restoration of the individual.

Basic Benefits Package

A defined set of health care services for which coverage must be available in each health insurance policy or plan.

Capitation

A managed care payment system under which providers are paid a per patient monthly enrollment fee that also may include a fee for case management. Capitation payments may or may not involve financial risk. Payments are made regardless of whether services are furnished.

Case Coordination

Is intended to support families, reduce health care costs, improve access to services, and resolve conflicts among services and their providers by maximizing resources and assisting patients. Care coordination includes services that assist individuals in gaining access to and coordination among necessary medical, social, educational, and other services required by individuals with a traumatic head injury and their families.

Case Management

Is frequently used in managed care settings, with the goal of limiting the financial risk for the insurer.

Copayment

The portion of a claim or medical expense that a member (or covered insured) must pay out of pocket, usually a fixed amount.

Coverage

Services or benefits provided through a health insurance plan.

Deductibles

The portion of the insured's (member's) health care expenses that must be paid out of pocket before any insurance coverage applies.

Fee for Service

Payment of specific amounts for specific services rendered on a service unit basis.

Gatekeeper

A primary care physician who is responsible for supervising patients' access to specialty care in a managed care environment.

Health Maintenance Organization (HMO)

As defined in the Health Maintenance Act of 1973 (P.L. 93-222) and its amendments (P.L. 94-460), a legal entity or organized system of health care that provides directly or arranges for a comprehensive range of basic and supplemental health care services to a voluntarily enrolled population in geographic area on a primarily prepaid and fixed periodic basis.

Indemnity Plan

Plan that reimburses physicians and other providers for health services performed or enrollees for medical expenses incurred.

Lifetime Caps

The maximum total dollar amount an insurance policy will pay out over the lifetime of the insured individual.

Long Term Care

Historically, the term has referred to health care services provided in a nursing home or other non-acute institution to those chronically impaired by physical or mental illness, age, or disability., More contemporary use of the term often augments this definition to include community-based alternatives for providing care to the chronically impaired outside of an institutional setting.

Limited-Risk Prepaid Health Plans (PHPs)

A PHP is an entity that either contracts on a prepaid, capitated-risk basis to provide services that are not risk-comprehensive (often ambulatory care only) or contracts on a non-risk basis. These plans, usually clinic or large group practices, do not assume full financial risk for a comprehensive service package.

Managed Care

The provision of health services through a single point of entry and formal enrollment where patient care is managed to assure an emphasis on preventative and primary care and a reduction in inappropriate utilization and costs.

Managed Care (Risked-Based)

"That body of organizational, financial, and management activities that should be implemented by professionals and any organizational entity that is at financial risk for the cost of medical or surgical services they provide." In Medicaid, this type of care arrangement is one in which the patient enrolls with a provider or health care plan furnishing one or more of the mandatory and optional services to which the patient is entitled under the state Medicaid plan. The managed care provider furnishes or arranges for the care and services listed in the provider's contract and may or may not "gatekeep" the patient with respect to other Medicaid care and services. This "gatekeeping" responsibility is also known as case management.

National Committee for Quality Assurance (NCQA)

The National Committee for Quality Assurance is a not-for-profit organization which evaluates managed care plans on six basic categories: quality improvement, physician credentials, members' rights and responsibilities, preventive health services, utilization management and medical records.

Network

The system of participating providers and institutions in a managed care plan. For the plan to pay for most care, an enrollee must use a network provider.

Out-of-Plan Services

Services that are not in the patient's managed care contract or that are furnished to patient's managed care network. These services are not reimbursed by the network except in limited circumstances (e.g., emergency care). Services may be paid directly by the Medicaid agency if they are covered under the state's Medicaid plan, but not part of the patient's managed care contract.

Physiatrist

A physician specializing in physical medicine and rehabilitation who is skilled in treating persons with disabilities.

Plan Administration

Management of a plan, including accounting, billing, personnel, marketing, legal services, purchasing, and servicing of accounts.

Pre-existing Condition

A disease or condition from which an individual has suffered, or continues to suffer, prior to purchasing health insurance.

Preferred Provider Organization (PPO)

Discounted fee-for-service indemnity product where participants have financial incentives to limit care to the panel of preferred providers but are allowed to go outside the network if they pay additional out-of-pocket costs.

Primary Care Case Management

One type of coordinated managed care arrangement under which providers are paid on a fee for service (or cost per encounter) basis plus a monthly care management fee for gatekeeping activities, for one or more types of Medicaid services. Providers are not at financial risk. Payments usually are not capitated.

Quality Assessment

The act of measuring quality of care, of detecting problems of quality, or of finding examples of good performance.

Quality Assurance

Applies broadly to an entire cycle of assessment which extends beyond problem identification, to verification of the problem, identification of what is correctable, initiation of interventions/improvements, and continual review to assure that identified problems have been adequately corrected and that no further problems have been engendered in the process.

Quality of Care

The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.

Risk

Refers to a system for paying managed care providers under which providers are paid a flat fee for one or more of the services they furnish under their contracts and are at financial risk in the event that patient costs exceed their payment. In the event that payments are greater than the cost of care, the provider can keep the difference.

Secondary Conditions

People with disabling conditions are often at risk of developing secondary conditions that can result in further deterioration in health status, functional capacity, and quality of life. Secondary conditions by definition are causally related to a primary disabling condition and include decubitus ulcers, contractures, physical deconditioning, cardiopulmonary conditions, and mental depression.

Secondary Disabilities

Secondary disabilities are defined as those medical conditions secondary to traumatic head or spinal cord injury that impair independent and productive lifestyles.

Self Insurance

Management in which health services are delivered by providers but the cost of these services is covered by the member's employer, not by the insurance firm.

Shared Risk

An arrangement in which financial liabilities are apportioned between two or more entities. For example, a health maintenance organization and a medical group may each agree to share the risk of excessive hospital cost over budgeted amounts on a 50-50 basis.

Missouri Head Injury Advisory Council

1996-1997

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